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February 12, 2010

Kathy Moore
West Valley Medical Center
1717 Arlington Street
Caldwell, ID 83605

Provider #130014

Dear Ms. Moore:

On **February 8, 2010**, a complaint survey was conducted at West Valley Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004464

Allegation #1: A patient was not provided physical privacy in the Emergency Department.

Findings: An unannounced visit was made to the hospital on 2/08/10. A tour of the Emergency Department was conducted. Fifteen medical records were reviewed. Patient rights documents were reviewed. Staff were interviewed.

A tour of the Emergency Department was conducted on 1/28/10 beginning at 10:50 AM. The department had 15 private rooms. Thirteen rooms had sliding glass doors and curtains inside the glass doors for privacy. Two of the rooms had privacy curtains with no glass doors. Several patient rooms were occupied and curtains and doors were closed. No issues with privacy were observed during the tour.

Two registered nurses, who were on duty in the Emergency Department, were interviewed on the afternoon of 1/28/10. Both were sensitive to maintaining the privacy of patients. Both stated they always closed the curtains when working with patients.

No privacy concerns were noted.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Physical assistance was not provided to a patient to ambulate or get dressed or while in the Emergency and Radiology Departments.

Findings: Based on observation and staff interview on 2/08/10, it was determined the Emergency Department was adequately staffed with nurses and nursing assistants.

Three registered nurses, including the Director of the Emergency Department, were interviewed on 2/08/10. All three staff stated patients were provided needed assistance and were concerned that a patient might not have been provided assistance. Two nurses who cared for the patient were interviewed but neither nurse specifically remembered the patient.

The medical record of the patient named in the allegation did not document an assessment of the patient's ability to ambulate or perform activities of daily living. The lack of documentation of this type of assessment is not unusual in emergency departments.

A review of patient grievances for the past three months revealed no other complaints regarding lack of assistance were documented.

The Director of the Emergency Department was interviewed on 2/08/10 at 2:00 PM. He stated he had investigated a patient complaint regarding a lack of assistance but had not been able to substantiate the complaint. He stated he had spoken with the complainant and apologized to her.

The Director of the Radiology Department was interviewed on 2/08/10 at 2:30 PM. He stated he had been unable to substantiate the complaint but said he had developed a five point action plan to address the patient's perceived concerns.

No evidence was found to indicate inadequate care was provided.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: A patient suffered bruising of her arm when an intravenous line was started in the Emergency Department.

Findings: The Emergency Department was staffed by registered nurses, all of whom were qualified to start intravenous lines.

The medical record of the patient named in the allegation documented an intravenous line was started on her with one stick.

The patient did not have a history of taking anticoagulant medication. No bruising was documented at the site of the intravenous line. Bruising is a common side effect of intravenous lines.

While the incident may have occurred, no evidence was found during the investigation to indicate inadequate care was provided.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: A patient was not adequately hydrated.

Findings: None of the fifteen medical records reviewed contained evidence that patients were dehydrated.

The medical record of the patient named in the allegation documented a patient who was in the hospital just under three hours. The record stated the patient did not have a history of nausea, vomiting, or diarrhea. She did not have a history of taking diuretic medications. The physician described her skin turgor as normal. A urine specimen was obtained which was described as clear and straw colored. An intravenous line was placed when the patient was admitted. While the amount of fluid the patient received was not documented, it was described at one point as running "wide open."

No evidence was found to indicate inadequate care was provided.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: Physican orders were not followed in relation to pain medication and x-rays.

Finding: Documentation was present that physician orders were followed for all fifteen medical records reviewed.

The medical record of the patient named in the allegation documented physician orders for pain medication, anti-spasmodic medication, and anti-nausea medication. These were all documented as given per the physician's orders. An order for a chest Xray was documented and this was also done.

No evidence was found to indicate inadequate care was provided.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/mlw